RETIREE MEDICAL PLAN OF THE SANTA MONICA POLICE OFFICERS' ASSOCIATION REIMBURSEMENT TRUST

Administered By: Benefit Programs Administration
Telephone: (562) 463-5050 Fax: (562) 463-5894 E-Mail: smpoatrust@bpabenefits.com www.smpoatrust.org

To: Eligible Retirees of the Santa Monica Police Officers' Association Reimbursement Trust

From: Administrative Office

Date: December 23, 2024

Subject: Required 2025 Annual Verification for Automatic Quarterly Reimbursement

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Automatic Quarterly Reimbursement is available only to those members: (1) who have their health insurance premium deducted from their CalPERS Benefit Warrant Statements (pension check stubs), and their monthly premium equals or exceeds their reimbursement amount under the Trust; or (2) whose claims submission reflects a consistent pattern of paying the same or equivalent monthly or annual premiums that equals or exceeds their monthly or annual reimbursement amount. As verification and authorization are required annually in January or early February 2025, you must now provide the necessary documentation for the current year and for the previous year, 2024 by:

1. Completing and signing the enclosed form; and

2. Returning the form to our office **along with copies of each of your CalPERS Benefit Warrant Statements (pension check stubs) from February 2024 through January 2025**, showing your health plan premium deduction; **or**

   Returning the form to our office **along with copies of monthly or annual premium payments (copies of cancelled checks) from February 2024 through January 2025**, showing that you have a consistent pattern of your monthly or annual premium payments equaling or exceeding your monthly or annual reimbursement amounts.

We ask that these documents be returned to our office no later than **January 23, 2025,** to avoid a delay in the processing of your reimbursement. Remember that an administrative fee of $25 will be deducted from each quarterly claims submission unless your enrollment is verified by providing the documents above.

Should you have any questions please call our office at 562-463-5050.

Thank you.

SANTA MONICA POLICE OFFICERS' ASSOCIATION REIMBURSEMENT BENEFIT TRUST
1200 Wilshire Boulevard, 5th Floor, Los Angeles, CA 90017
Telephone (562) 463-5050 • FAX (562) 463-5894 • Email to smpoatrust@bpabenefits.com

REIMBURSEMENT CLAIM VERIFICATION FORM

Plan Participant Name: ____
(PRINT NAME)

Spouse Name: ____________________________________

Dependent(s) Name & DOB: ____

____

Participant's Address: ____

Daytime Phone: ____

Email: ____

***PLEASE* update the Trust Administrator of any changes to the contact information provided above**

1. Election of Coverage(s). As a member of the Retiree Medical Plan of the Santa Monica Police Officers' Association Reimbursement Trust, I hereby request to participate in the 2025 Automatic Quarterly Reimbursement program and agree to comply with all submission requirements in order to continue in the program.

2. Reimbursement. I understand that by signing and submitting this form the Trust will continue to make quarterly payments directly to me as reimbursement for my health insurance premium payments. I understand that I must provide copies of: (1) all CalPERS Benefit Warrant Statements (pension check stubs); or (2) copies of monthly or annual premium payments at the beginning of each new calendar year in order for the Trust to verify that I was correctly reimbursed. For example, I must provide copies of all of my 2025 CalPERS check stubs in January or early February 2026. If my premium payments change or terminate, for any reason, it is my obligation to promptly advise the Trust of same. If I fail to do so, I agree to reimburse the Trust for any overpayments, as well as to pay the Trust for penalties, loss of interest earned, and attorney's fees and costs, if so incurred.

3. Annual Verification. I understand that the premium reimbursement will not continue until I have completed and signed this form and submitted proof of deductions as required by the Plan and returned it to the Administrative Office.

I understand that I am required to furnish verification annually or more frequently, if needed, as determined by the Trustees. I will be asked to verify that I remain: (1) covered by the same health insurance and that policy was paid for by payroll deduction from my CalPERS Benefit Warrant Statement (pension check stub); or (2) that I am paying the same or equivalent monthly or annual premiums that equals or exceeds my monthly or annual reimbursement amounts.

I am enrolled in the following CalPERS Plan or other health plans and attached is proof of that premium being deducted from my CalPERS Benefit Warrant Statement (pension check stub) or proof of other premium payment amounts.

NAME OF HEALTH INSURANCE PLAN(s):

____

My 2025 monthly health insurance premium is $____________ Insured Beneficiary: ☐ Self ☐ Spouse ☐ Child

Other 2025 monthly health insurance premium is $__________ Insured Beneficiary: Self Spouse ☐ Child

Total 2025 monthly health insurance premiums is $__________ Insured Beneficiary: Self Spouse ☐ Child

Please indicate below whether you or your spouse are (or not) receiving Cash in Lieu of medical benefits from another employer-sponsored plan.

Can you or your spouse receive Cash in Lieu for your Medical Coverage from your present employer Yes/ No and,

Are you or your spouse receiving Cash in Lieu for your Medical Coverage from your present employer Yes/ No

If yes, provide the monthly amount you or your spouse are receiving as a benefit for the Cash in Lieu $___________.

If you are currently employed, whether on a part-time or full-time basis, please provide the name of your employer: ____

Please notify the Trust office within 30 days of termination or reduction of any claimed premium expenses or Cash in Lieu received.

4. I understand that I am responsible for all premium payments to the health insurance plan and that the Trust will reimburse me upon proof of my payment to the health insurance plan.

5. I understand that Reimbursement will be available only for the "Premium" as defined in Article I, section 1.16 of the Plan, up to the Reimbursement Amount described in Article III, section 3.2 of the Plan.

6. I agree to notify the Trust within thirty (30) days of any termination or any reduction in the insurance premium payable below my reimbursement amount (as described in Article III, section 3.2 of the Plan) through my CalPERS Benefit Warrant Statement (pension check stub) or through other insurance premium payment amounts .

7. By my signature below, I am attesting to the Trust that I do not expect any change in my insurance coverage or my payroll deduction from my CalPERS Benefit Warrant Statement (pension check stub) or through other premium payments for the year in which this verification is authorized.

8. I also agree to indemnify and reimburse the Trust on demand for any liability it may incur for failure to withhold federal, state or local income tax from any Reimbursement I receive for a non-qualifying medical expense or premium up to the amount of additional tax owed by me. For example, a non-qualifying medical expense or premium is an expense that does not qualify as a Premium under Article I, section 1.16 of the Plan.

9. I understand that the Trust may pursue legal and equitable remedies against me for any false, fraudulent, or misleading information provided (i.e., failure to advise the Trust of my termination or reduction of insurance coverage, change in insurance premium, and/or suspension of payroll deductions).

10. I understand that effective January 1, 2024, the Plan can reimburse insurance premiums that were paid pre-tax with the understanding that any portion reimbursed by this Plan will be reported as income via a Form 1099. (Payment "pre-tax" means that I paid the premium with income that is not taxable to me, e.g., the premium amount was deducted from my or my spouse's income prior to taxation, or the premium was paid through a cafeteria plan on a pre-tax basis.

I certify under penalty of perjury that the information I have given above is true and correct, that I have read, understood, and agree to the terms set out above in this form.

________________________________	____________________
Participant's Signature	Date
________________________________	____________________
Administrative Representative Approval	Date Approved